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6 **STATE OF WASHINGTON**  
7 **OFFICE OF THE INSURANCE COMMISSIONER**

8  
9 *In the Matter of*

10 SEATTLE CHILDREN'S  
11 HOSPITAL

Order No. 13-0293

OIC STAFF'S HEARING  
BRIEF

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13  
14 The Hospital's Demand for Hearing in this case challenges the OIC's  
15 July 31, 2013 approvals of the Washington Health Benefit Exchange plans  
16 of two health care service contractors, Premera Blue Cross, and BridgeSpan  
17 Health Company, based upon the claim that the carriers' failure to contract  
18 with the Hospital renders their Health Benefit Exchange plan provider  
19 networks legally inadequate under state and federal law.

20 The Hospital bases its claim on two contentions: (1) that the carriers  
21 must include the Hospital in their networks as a contracted preferred  
22 provider because the Hospital is an "essential community provider" under  
23 the Affordable Care Act; and (2) that the plans fail to provide adequate or  
24 sufficient network coverage for pediatric services, one of the ACA's ten  
25 essential benefits, because some of the pediatric specialty procedures and  
26 services provided at Seattle Children's are not available elsewhere.

1 For the reasons set forth in the OIC staff's prior Motion to Dismiss,  
2 the staff believes the Hospital's claims are non justiciable and devoid of  
3 substantive legal merit.

4 This memorandum is submitted to further address the law governing  
5 network adequacy and the burden of proof.

6 **I. Burden of Proof**

7 Nothing in the insurance code allocates the burden of proof when a  
8 hearing is demanded to litigate the insurance commissioner's approval of a  
9 rate or form filing. The Washington Administrative Procedure Act, RCW  
10 Chapter 34.05, is likewise silent on the question, although it is noteworthy  
11 that RCW 34.05.570(1)(a) provides for purposes of judicial review that  
12 unless that chapter or another statute provides otherwise, "(t)he burden of  
13 demonstrating the invalidity of agency action is on the party asserting  
14 invalidity."

15 Because no statute allocates the burden of proof in this case, the question  
16 of which party carries the burden is subject to the default rule that the  
17 burden of demonstrating the invalidity of an agency action is on the party  
18 asserting invalidity and seeking relief. On point is *Schaffer v. Weast*, 546  
19 U.S. 49, 57 (2005), affirming the decision of an administrative law judge  
20 allocating the burden of proof to the parents of a disabled child who had  
21 requested an administrative hearing to contest a school's Individualized  
22 Education Plan under the federal Individuals with Disabilities Education  
23 Act:

24 When we are determining the burden of proof under a statutory cause  
25 of action, the touchstone of our inquiry is, of course, the statute. The  
26 plain text of IDEA is silent on the allocation of the burden of  
persuasion. We therefore begin with the ordinary default rule that

1 plaintiffs bear the risk of failing to prove their claims. McCormick §  
2 337, at 412 ("The burdens of pleading and proof with regard to most  
3 facts have been and should be assigned to the plaintiff who generally  
4 seeks to change the present state of affairs and who therefore  
5 naturally should be expected to bear the risk of failure of proof or  
6 persuasion"); C. Mueller & L. Kirkpatrick, Evidence § 3.1, p 104 (3d  
7 ed. 2003) ("Perhaps the broadest and most accepted idea is that the  
8 person who seeks court action should justify the request, which  
9 means that the plaintiffs bear the burdens on the elements in their  
10 claims").

11 As the Supreme Court's decision in *Schaffer* makes clear, where no  
12 statute allocates the burden of proof in an administrative adjudicatory  
13 proceeding, the default rule applies and the burden of proof falls on the  
14 party who challenges an administrative action and seeks relief. Under the  
15 default rule, the Hospital bears the burden of proof here just as it would if it  
16 were challenging the Commissioner's action in court.

17 In determining whether the Hospital's burden of proof is met, the  
18 Presiding Officer should bear in mind that the Insurance Commissioner has  
19 broad powers over the control, supervision and direction of the insurance  
20 business. *Federated American Insurance Company v. Marquardt*, 108  
21 Wn.2d 651, 654, 741 P.2d 18 (1987), citing 2A G. Couch, *Insurance* § 21:5,  
22 at 240 (2d ed. 1984). As stated in *Marquardt*, supra, at 108 Wn.2d 656,  
23 "the Commissioner's interpretation of his own regulation is entitled to great  
24 weight." In accord, see *Credit General Ins. Co. v. Zewdu*, 82 Wn. App.  
25 620, 627, 919 P.2d 93 (1996), refusing to enforce an automobile policy  
26 exclusion that had been disapproved by the Commissioner, in which the  
court observed as follows:

In addition, although a commissioner cannot bind the courts, the  
court appropriately defers to a commissioner's interpretation of  
insurance statutes and rules. *Bailey v. Allstate Ins. Co.*, 73 Wn. App.

1 442, 447, 869 P.2d 1110 (1994); *Retail Store Employees Union*, 87  
2 Wn.2d at 898 (“We may place greater reliance than usual upon an  
3 administrative statutory interpretation in this case because the  
4 Commissioner has been entrusted with very broad discretion and  
responsibility in the administration of RCW 48.19.170(2)(b).

5 In summary, the Hospital bears the burden of proof in this case.

6 Although the Hospital’s burden is a preponderance as to questions of pure  
7 fact, on questions involving discretion and the interpretation of the network  
8 adequacy rules, the Hospital must demonstrate that the OIC’s interpretation  
9 was clearly erroneous or constituted an abuse of discretion.

10 **II. State Network Adequacy Standards**

11 **A. State Statutes.**

12 The Washington statutory standards for network adequacy are set  
13 forth in RCW 48.43.515. The pertinent subsections of this statute provide  
14 as follows:

15 (1) Each enrollee in a health plan must have adequate choice among  
16 health care providers.

17 ...

18 (4) Each carrier must provide for appropriate and timely referral of  
19 enrollees to a choice of specialists within the plan if specialty care is  
20 warranted. If the type of medical specialist needed for a specific  
21 condition is not represented on the specialty panel, enrollees must  
have access to nonparticipating specialty health care providers.

22 ...

23 (8) Every carrier shall meet the standards set forth in this section and  
24 any rules adopted by the commissioner to implement this section. In  
25 developing rules to implement this section, the commissioner shall  
26 consider relevant standards adopted by national managed care  
accreditation organizations and state agencies that purchase managed  
health care services.

1 Also pertinent to the Hospital's claims is RCW 48.44.030, which  
2 provides in relevant part as follows:

3 If any of the health care services which are promised in any such  
4 agreement are not to be performed by the health care service  
5 contractor, or by a participating provider, such activity shall not be  
6 subject to the laws relating to insurance, provided provision is made  
7 for reimbursement or indemnity of the persons who have previously  
8 paid, or on whose behalf prepayment has been made, for such  
9 services.

8 **B. State Regulations.**

9 The Insurance Commissioner's regulation implementing RCW  
10 48.43.515 is set forth in WAC 284-43-200<sup>1</sup>. The pertinent subsections of  
11 this regulation in effect at the time these plans were reviewed and approved  
12 provide as follows:

13  
14 (1) A health carrier shall maintain each plan network in a manner  
15 that is sufficient in numbers and types of providers and facilities to  
16 assure that all health plan services to covered persons will be  
17 accessible without unreasonable delay. Each covered person shall  
18 have adequate choice among each type of health care provider,  
19 including those types of providers who must be included in the  
20 network under WAC 284-43-205. In the case of emergency services,  
21 covered persons shall have access twenty-four hours per day, seven  
22 days per week. The carrier's service area shall not be created in a  
23 manner designed to discriminate against persons because of age, sex,  
24 family structure, ethnicity, race, health condition, employment status,  
25 or socioeconomic status. Each carrier shall ensure that its networks  
26 will meet these requirements by the end of the first year of initial  
operation of the network and at all times thereafter.

(2) Sufficiency and adequacy of choice may be established by the

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<sup>1</sup> WAC 284-43-200 was amended and two new sections, WAC 284-43-201 and WAC 284-43-203, were added to WAC Chapter 284-43 by rule effective May 26, 2014. Because this rule took effect after the OIC approved the two plans at issue in this matter, its text has not been included herein.

1 carrier with reference to any reasonable criteria used by the carrier,  
2 including but not limited to: Provider-covered person ratios by  
3 specialty, primary care provider-covered person ratios, geographic  
4 accessibility, waiting times for appointments with participating  
5 providers, hours of operation, and the volume of technological and  
6 specialty services available to serve the needs of covered persons  
7 requiring technologically advanced or specialty care. Evidence of  
8 carrier compliance with network adequacy standards that are  
9 substantially similar to those standards established by state agency  
10 health care purchasers (e.g., the state health care authority and the  
11 department of social and health services) and by private managed  
12 care accreditation organizations may be used to demonstrate  
13 sufficiency. At a minimum, a carrier will be held accountable for  
14 meeting those standards described under WAC 284-43-220<sup>2</sup>.

15 (3) In any case where the health carrier has an absence of or an  
16 insufficient number or type of participating providers or facilities to  
17 provide a particular covered health care service, the carrier shall  
18 ensure through referral by the primary care provider or otherwise  
19 that the covered person obtains the covered service from a provider  
20 or facility within reasonable proximity of the covered person at no  
21 greater cost to the covered person than if the service were obtained  
22 from network providers and facilities, or shall make other  
23 arrangements acceptable to the commissioner.

24 (4) The health carrier shall establish and maintain adequate  
25 arrangements to ensure reasonable proximity of network providers  
26 and facilities to the business or personal residence of covered  
persons. Health carriers shall make reasonable efforts to include  
providers and facilities in networks in a manner that limits the  
amount of travel required to obtain covered benefits. For example, a  
carrier should not require travel of thirty miles or more when a  
provider who meets carrier standards is available for inclusion in the  
network and practices within five miles of enrollees. In determining  
whether a health carrier has complied with this provision, the  
commissioner will give due consideration to the relative availability  
of health care providers or facilities in the service area under  
consideration and to the standards established by state agency health  
care purchasers. Relative availability includes the willingness of

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<sup>2</sup> WAC 284-43-220 describes the electronic network reports a carrier must file with the OIC.

1 providers or facilities in the service area to contract with the carrier  
2 under reasonable terms and conditions.

3 WAC 284-43-205, implementing the every category of provider  
4 requirement of RCW 48.43.045, in turn recognizes the right of health  
5 carriers to utilize restricted networks, providing in pertinent part as follows:

6 (4) This section does not prohibit health plans from using restricted  
7 networks. Health carriers offering plans with restricted networks may  
8 select the individual providers in any category of provider with  
9 whom they will contract or whom they will reimburse. A health  
10 carrier is not required by RCW 48.43.045 or this section to accede to  
11 a request by any individual provider for inclusion in any network for  
12 any health plan. Health plans that use "gatekeepers" for access to  
13 specialist providers may use them for access to specified categories  
14 of providers.

### 13 **C. Summary of Applicable State Law**

14 In summary, the pertinent provisions of Washington law governing  
15 networks require that a network offer an adequate choice of providers and  
16 sufficient numbers and types of providers and facilities to assure that all  
17 health plan services to covered persons will be accessible without  
18 unreasonable delay. Washington law expressly permits restricted networks,  
19 provides that carriers do not have to contract with any particular provider,  
20 and recognizes that out-of-network specialists will sometimes be needed to  
21 provide covered services. Washington law allows health care service  
22 contractors to make provision for payment for these out-of-network  
23 provider obligations and allows them to make arrangements satisfactory to  
24 the Commissioner to protect enrollees from added costs when an enrollee  
25 needs to see an out-of-network specialist to obtain a covered service.  
26 Finally, Washington law allows carriers who create a network from scratch

1 a one year period to bring the network into full compliance with the state  
2 law's network adequacy requirements.

3 **III. Federal Law**

4 **A. Federal Statutes**

5 42 USCS § 18031(c)(1)(B) requires the Secretary of the United  
6 States Department of Health and Human Services by regulation to  
7 "establish criteria for certification of health plans as qualified health plans"  
8 and instructs the Secretary in pertinent part that such regulations shall  
9 require that to be certified, a plan shall, at a minimum:

10 (B) ensure a sufficient choice of providers (in a manner consistent  
11 with applicable network adequacy provisions under section 2702(c) of  
12 the Public Health Service Act [42 USCS § 300gg-1(c)]<sup>3</sup>, and provide  
information to enrollees and prospective enrollees on the availability  
of in-network and out-of-network providers;

13 (C) include within health insurance plan networks those essential  
14 community providers, where available, that serve predominately low-  
15 income, medically-underserved individuals, such as health care  
providers defined in section 340B(a)(4) of the Public Health Service

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<sup>3</sup> 42 USCS § 399gg-1©, provides as follows:

17 (c) Special rules for network plans.

18 (1) In general. In the case of a health insurance issuer that offers health insurance  
coverage in the group and individual market through a network plan, the issuer may--

19 (A) limit the employers that may apply for such coverage to those with eligible  
individuals who live, work, or reside in the service area for such network plan; and

20 (B) within the service area of such plan, deny such coverage to such employers  
and individuals if the issuer has demonstrated, if required, to the applicable State  
21 authority that--

22 (i) it will not have the capacity to deliver services adequately to enrollees  
of any additional groups or any additional individuals because of its obligations to  
23 existing group contract holders and enrollees, and

24 (ii) it is applying this paragraph uniformly to all employers and  
individuals without regard to the claims experience of those individuals, employers and  
25 their employees (and their dependents) or any health status-related factor relating to such  
individuals[,] employees and dependents.  
26

1 Act [42 USCS § 256b(a)(4)]<sup>4</sup> and providers described in section  
2 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 USCS § 1396r-  
3 8(c)(1)(D)(i)(IV)]<sup>5</sup> as set forth by section 221 of Public Law 111-8,  
4 except that nothing in this subparagraph shall be construed to require  
any health plan to provide coverage for any specific medical  
procedure;

5 (D) (i) be accredited with respect to local performance on clinical  
6 quality measures such as the Healthcare Effectiveness Data and  
7 Information Set, patient experience ratings on a standardized  
8 Consumer Assessment of Healthcare Providers and Systems survey,  
9 as well as consumer access, utilization management, quality  
10 assurance, provider credentialing, complaints and appeals, network  
11 adequacy and access, and patient information programs by any entity  
12 recognized by the Secretary for the accreditation of health insurance  
13 issuers or plans (so long as any such entity has transparent and  
14 rigorous methodological and scoring criteria); or (ii) receive such  
15 accreditation within a period established by an Exchange for such  
16 accreditation that is applicable to all qualified health plans;

17 A qualified health plan must also provide coverage for ten essential  
18 benefits. 42 USCS § 10822(b)(1) provides-

19 (b) Essential health benefits.

20 (1) In general. Subject to paragraph (2), the Secretary shall define the  
21 essential health benefits, except that such benefits shall include at least the  
22 following general categories and the items and services covered within the  
23 categories:

24 (A) Ambulatory patient services.

25 (B) Emergency services.

26 (C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including  
behavioral health treatment.

(F) Prescription drugs.

<sup>4</sup> 42 USCS § 256 identifies certain entities that are eligible for federal grants to assist in  
the development of integrated health care delivery systems to serve communities of  
individuals who are uninsured and individuals who are underinsured.

<sup>5</sup> 42 USCS § 1396r – 8 identifies certain entities that are eligible to participate in drug  
manufacturer rebates available under rebate agreements negotiated by the federal  
government with drug manufacturers.

- 1 (G) Rehabilitative and habilitative services and devices.  
2 (H) Laboratory services.  
3 (I) Preventive and wellness services and chronic disease  
4 management.  
5 (J) Pediatric services, including oral and vision care.

#### 6 **B Federal Regulations**

7 The federal network adequacy regulation is set out in 45 CFR §  
8 156.230, headed "Network adequacy standards," and provides as follows:

9 (a) General requirement. A QHP issuer must ensure that the provider  
10 network of each of its QHPs, as available to all enrollees, meets the  
11 following standards--

12 (1) Includes essential community providers in accordance with §  
13 156.235;

14 (2) Maintains a network that is sufficient in number and types of  
15 providers, including providers that specialize in mental health and  
16 substance abuse services, to assure that all services will be accessible  
17 without unreasonable delay; and,

18 (3) Is consistent with the network adequacy provisions of section  
19 2702(c) of the PHS Act.

20 (b) Access to provider directory. A QHP issuer must make its  
21 provider directory for a QHP available to the Exchange for  
22 publication online in accordance with guidance from the Exchange  
23 and to potential enrollees in hard copy upon request. In the provider  
24 directory, a QHP issuer must identify providers that are not accepting  
25 new patients.

26 45 CFR § 156.235(a)(1) and (3) in turn provide that "a QHP issuer  
must have a sufficient number and geographic distribution of essential  
community providers, where available, to ensure reasonable and timely  
access to a broad range of such providers for low-income, medically  
underserved individuals in the QHP's service area, in accordance with the

1 Exchange's network adequacy standards” and that “nothing in this  
2 requirement shall be construed to require a QHP to provide coverage for  
3 any specific medical procedure provided by the essential community  
4 standard.”

5 Finally, with respect to the ten essential health benefits, 45 CFR §  
6 147.150(a), provides that a “health insurance issuer offering health  
7 insurance coverage in the individual or small group market must ensure that  
8 such coverage includes the essential health benefits package as defined in  
9 section 1302(a) of the Affordable Care Act effective for plan or policy years  
10 beginning on or after January 1, 2014.”

### 11 **C. Federal Guidance**

12 The Center for Medicare and Medicaid Services has instructed filers  
13 that a 2014 plan that includes twenty percent of the essential community  
14 providers in the carrier’s service area will satisfy the essential community  
15 provider requirement and that an issuer may qualify with as few as ten  
16 percent. The OIC will offer the CMS advisory letter to issuers dated April  
17 5, 2013, page 7, that was attached to the previously filed Declaration of  
18 Molly Nollette as exhibit “F,” and which provides in part as follows:

19  **Safe Harbor Standard:** An application for QHP certification that  
20 demonstrates compliance with the standards outlined in this  
21 paragraph will be determined to meet the regulatory standard  
22 established by 45 C.F.R. § 156.235(a) without further documentation.  
23 First, the application demonstrates that at least 20 percent of available  
24 ECPs in the plan’s service area participate in the issuer’s provider  
25 network(s). In addition to achieving 20 percent participation of  
26 available ECPs, the issuer offers contracts prior to the coverage year  
to:

- o All available Indian providers in the service area, using the model QHP Addendum for Indian providers developed by CMS; and
  - o At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available. CMS may verify the offering of contracts after certification.
- Minimum Expectation:** An issuer application that demonstrates that at least 10 percent of available ECPs in the plan’s service area participate in the issuer’s provider network(s) for that plan will be determined to meet the regulatory standard, provided that the issuer includes as part of its application a satisfactory narrative justification describing how the issuer’s provider network(s), as currently designed and after taking into account new 2014 enrollment, provides an adequate level of service for low-income and medically underserved enrollees.

The CMS filing instructions for a qualified health plan application recognize six categories of essential community providers: “Federally Qualified Health Center (FQHC), Hospital, Ryan White HIV Provider, Indian Provider, Family Planning Provider, and Other ECP.” See previously filed Declaration of Molly Nollette, Exh. “G”, page 7-1, note 1.) Table 7-2 of this guidance document identifies the “hospital” category as including disproportionate share hospitals, children’s hospitals, rural referral centers, sole community hospitals, free-standing cancer centers, and critical access hospitals.

CMS also provided states with a data tool to calculate whether a QHP applicant’s list of essential community providers meets the federal ECP requirements. The templates filed by both carriers here listing their contracted ECPs were run through this tool and both carriers passed without Seattle Children’s Hospital as a network provider.

1           **D. Federal Law Summary**

2           Federal network adequacy requirements do not contain geographic  
3 and proximity to care requirements comparable to those set out in  
4 Washington law and they do not contain comparable protections from  
5 added cost to enrollees when a carrier is required to provide out of network  
6 specialty care. Save for the federal essential community provider  
7 requirements, Washington network adequacy law sets a floor that at least  
8 equals, and the OIC believes exceeds, the minimum requirements of federal  
9 law. Although federal law requires qualified health plans to provide  
10 “coverage” for ten essential benefit categories, including pediatric care, like  
11 Washington law, the Affordable Care Act does not require that every  
12 specialty service that might fall within one of the ten benefit categories be  
13 available from a network preferred provider.

14           Finally, the federal ECP requirement does not require a carrier to  
15 provide coverage for any particular procedure and requires only one ECP  
16 hospital per county, a standard which both of these carriers met. Although  
17 Seattle Children’s Hospital qualifies as an essential community provider  
18 hospital, a pediatric specialty hospital is simply one of several types of  
19 institutions that satisfy the ECP “hospital” category. Each of these carriers  
20 has in its network at least one ECP hospital in King County where Seattle  
21 Children’s Hospital is located.

22           **IV. Conclusion**

23           As the foregoing statutes, regulations, and federal guidance makes  
24 clear, even though Seattle Children’s Hospital may be an “essential  
25 community provider,” it is not indispensable and neither the hospital nor  
26 any specific medical procedure it offers need be included in a carrier’s

1 | contracted network in order for the plan to have an adequate network and  
2 | constitute a qualified health plan under federal law.

3 |         The same is true under state law. As noted, the state statutory  
4 | standard for network adequacy is set out in RCW 48.43.515(1) which  
5 | requires health plan issuers to provide enrollees an “adequate choice among  
6 | health care providers.” This statute and the other state law provisions cited  
7 | above contemplate the inevitable circumstance that some specialty services  
8 | covered by a plan will not be available from a participating provider. The  
9 | carriers here have made the arrangements required by RCW 48.44.030 to  
10 | cover this circumstance, and they have made written alternative  
11 | arrangements in their filings satisfactory to the OIC that they will provide  
12 | access to these out-of-net work services at no greater cost to enrollees than  
13 | if the provider was in network.

14 |         Given the uniformity of benefits required by the ACA and its open  
15 | enrollment requirement that carriers accept enrollees regardless of their  
16 | health, a QHP issuer’s provider reimbursement rates and network design is  
17 | one of the few plan features where a carrier can innovate to reduce  
18 | premiums. As the Washington Health Benefit Exchange enters its second  
19 | plan year, fostering carrier innovation, competition, and meaningful  
20 | consumer choice is an important goal of the Commissioner.

21 |         The Hospital’s desire to subsidize its research, teaching, and charity  
22 | care by obtaining maximum commercial rates from QHP issuers for routine  
23 | as well as unique services is understandable. However, federal and state  
24 | network adequacy laws do not give the Hospital the bargaining leverage  
25 | and unilateral price control it seeks. Whatever economic leverage the  
26 | Hospital has must come from the market place and competition. Even if the

1 Hospital is deemed an intended beneficiary of state and federal network  
2 adequacy laws, which it is not, and even if its claims raise justiciable issues  
3 as to which effective and final relief can be granted, which they do not, the  
4 Hearing Officer's prior legal ruling in the Coordinated Care case that the  
5 law does not require carriers to include pediatric hospitals in their network  
6 accurately reflects the agency's position and is legally correct. The two  
7 networks at issue in this case meet the minimum legal standards under both  
8 state and federal law.

9 The OIC Staff therefore respectfully request that the "relief"  
10 demanded by the Hospital be denied and that a final order be entered  
11 affirming the OIC's July 31, 2013 approval of the Premera and Bridgespan  
12 2014 Washington Health Benefit Exchange plans.

13  
14 DATED this 11<sup>th</sup> day of August, 2014.

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16   
17 Charles D. Brown  
18 Senior Insurance Enforcement Specialist  
19 Legal Affairs Division  
20 Office of Insurance Commissioner  
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